DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 8

2. STATE: VIRGINIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 3.6 million
b. FFY 2001 $ 14.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Supplement 1, pp 1-70.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Entire Nursing Home Payment system and Appendix II.

Retain other Appendices.

10. SUBJECT OF AMENDMENT:
Nursing Home Payment System

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis G. Smith

14. TITLE:
Director

15. DATE SUBMITTED: 8/24/2000

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad St., Suite 1300
Richmond, VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/26/00

18. DATE APPROVED: December 18, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/00

20. SIGNATURE OF REGIONAL OFFICIAL: Claudette V. Campbell /tad

21. TYPED NAME: CLAUDETTE V CAMPBELL

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID & STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

12VAC30-90-20. Nursing home payment system; generally.

A. Effective October 1, 1990, the payment methodology for nursing facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in this part.

B. Three separate cost components are used: capital cost, operating cost and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

C. Effective July 1, 2000, in determining the ceiling limitations, there shall be direct patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for nursing facilities in the Virginia portion of the Washington DC-MD-VA MSA, for NFs with less than 61 beds in the rest of the state, and for NFs with more than 60 beds in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A nursing facility located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

D. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in 12 VAC 30-90-

35, 12VAC30-90-40, 12VAC30-90-60, and 12VAC30-90-80, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare principles of reimbursement and Medicaid principles of reimbursement in effect on June 30, 2000, except that those that are defined as skilled nursing facilities (SNFs) and are operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall not be subject to the routine cost limits that are normally required and applicable under Medicare principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

E. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270) and must be identifiable and verified by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supersede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

Subpart II

Rate Determination Procedures

Article 1

Plant Cost Component

12VAC30-90-30 through 12VAC30-90-33. Repealed.

12VAC30-90-34. Purchases of nursing facilities (NF).

In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider and notify DMAS of the sale within 30 days of the date legal title passed to the purchaser.

12VAC30-90-35. Nursing Facility Capital Payment Methodology

Definitions. The terms used in this article shall be defined as follows:

"Date of acquisition" means the date legal title passed to the buyer. If a legal titling date is not determinable for a nursing facility building, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

"Facility average age" means for a facility the weighted average of the ages of all capitalized assets of the facility, with the weights equal to the expenditures for those assets. The calculation of average age shall take into account land improvements, building and fixed equipment, and major movable equipment. The basis for the calculation of average age shall be the schedule of assets submitted annually to the Department in accordance with the provisions of this section.

"Facility imputed gross square feet" means a number that is determined by multiplying the facility's number of licensed beds by the imputed number of gross square feet per bed. The imputed number of gross square feet per bed shall be 405 for facilities of 90 or fewer beds, and 385 for facilities of more than 90 beds. Number of licensed beds shall be the number on the last day of the provider's most recent fiscal year end.

"Factor for land and soft costs" means a factor equaling 1.299 which adjusts the construction cost amount to recognize land and capitalized costs associated with construction of a facility, that are not part of the RSMeans construction cost amount.

"Fixed capital replacement value" means an amount equal to the RSMeans 75th percentile nursing home construction cost per square foot, times the applicable RSMeans historical cost index factor, times the factor for land and soft costs, times the applicable RSMeans location factor, times facility imputed gross square feet.

"FRV depreciation rate" means a depreciation rate equal to 1.5%.

"Movable capital replacement value" means a value equal to $3,475.00 in SFY2001, and shall be increased each July 1st by the same RSMeans historical cost index factor that is used to calculate the fixed capital replacement value.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

"RSMeans 75th percentile nursing construction cost per square foot" means the 75th percentile value published in the most recent available edition of Building Construction Cost Data. In the 2000 edition of the RSMeans publication this value is $110, which is reported as a January 2000 value.

"RSMeans historical cost index factor" means the ratio of the two most recent RSMeans Historical Cost Indexes published in the most recent available edition of Building Construction Cost Data. In the 1999 edition of this RSMeans publication these two values are 117.6 (for 1999) and 115.1 (for 1998). The ratio of these values, and therefore the factor to be used would be 1.022. This factor would be used to adjust the January 2000 value for the one year of change from January 2000 to January 2001, the mid-point of the prospective rate year (SFY2001). The resulting cost value that would be used in SFY2001 is $112.42. The indexes used in this calculation do not match the time period for which a factor is needed. They relate to 1998 and 1999, while 2000 and 2001 would be ideal. However, RSMeans does not publish index forecasts, so the most recent available indexes shall be used.

"RSMeans location factors" means those published in the most recent available edition of Square Foot Costs. The 2000 location factors are shown in the following table. They will be updated annualiy and distributed to providers based upon the most recent available data.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

TABLE 1

RSMEANS COMMERCIAL CONSTRUCTION COST

LOCATION FACTORS (2000)

Zip Code	Principal City	Location Factor
220-221	Fairfax	0.90
222	Arlington	0.90
223	Alexandria	0.91
224-225	Fredericksburg	0.85
226	Winchester	0.80
227	Culpeper	0.80
228	Harrisonburg	0.77
229	Charlottesville	0.82
230-232	Richmond	0.85
233-235	Norfolk	0.82
236	Newport News	0.82
237	Portsmouth	0.81
238	Petersburg	0.84
239	Farmville	0.74
240-241	Roanoke	0.77
242	Bristol	0.75
243	Pulaski	0.70
244	Staunton	0.76
245	Lynchburg	0.77
246	Grundy	0.70

"Rental rate" means for a prospective year a rate equal to two percentage points plus the yield on US Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data are available, as published by the Federal Reserve. Rental rates may not fall

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

below 9% or exceed 11% and will be updated annually on or about July 1st each year. The rate will be published and distributed to providers annually. Changes in the rental rate shall be effective for the providers' fiscal year beginning on or after July 1st.

"Required occupancy percentage" means an occupancy percentage of 90%.

A. Fair Rental Value Payment for Capital. Effective for dates of service on or after July 1, 2000, the state agency shall pay nursing facility capital related costs under a Fair Rental Value (FRV) methodology. The payment made under this methodology shall be the only payment for capital related costs, and no separate payment shall be made for depreciation or interest expense, lease costs, property taxes, insurance, or any other capital related cost. This payment is considered to cover costs related to land, buildings and fixed equipment, major movable equipment, and any other capital related item. This shall be the case regardless of whether the property is owned or leased by the operator.

B. FRV Rate Year. The FRV payment rate shall be a per-diem rate determined each year for each facility, using the most recent available data from settled cost reports, or from other verified sources as specified herein. The per-diem rate shall be determined prospectively and shall apply for the entire fiscal year. Each provider shall receive a new capital per diem rate each year effective at the start of the provider's fiscal year. Data elements that are provider specific shall be revised at that time and shall rely on the filed cost report and schedule of assets of the previous year. Data elements that are not provider specific, including those published by RSMeans and the rental rate, shall be determined annually on or about July 1st. and shall apply to provider fiscal years beginning on or after July 1st. That is, each July 1st DMAS shall determine the RSMeans values and the rental rate, and these shall apply to all provider fiscal years beginning on or after July 1st.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

C. Transition Policy. Nursing facilities enrolled in the Medicaid program prior to July 1, 2000 shall be paid for capital related costs under a transition policy from July 1, 2000 through June 30, 2005. Facilities and beds paid under the transition policy shall receive payments as follows:

1. During SFY2001, each facility's capital per diem shall be the facility's capital per diem on June 30, 2000. The methodology under which this per diem is determined is the plant cost reimbursement methodology in effect as of June 30, 2000.

2. During SFY2002 through SFY2005, each facility shall have a capital per diem that is a percentage of the per diem of June 30, 2000, plus a percentage of the modified FRV per diem. The percentage associated with the June 30, 2000 per diem shall be 75% for services provided in SFY2002, 50% for services provided in SFY2003, 25% for services provided in SFY2004, and 0% for services provided in SFY2005. The percentage associated with the modified FRV per diem shall be one minus the percentage associated with the June 30, 2000 per diem. The modified FRV per diem shall be equal to the FRV per diem described in this section, except that it can be no greater than the June 30, 2000, per diem plus $1, and no less than the June 30, 2000, per diem minus $3. If savings are identified due to facilities being fully subject to the FRV per diem, the upper limit of the modified FRV per diem shall be increased prospectively in the following state fiscal year, by an amount estimated to expend the savings as provided in subsection F of this section.

3. Prior to July 1, 2004, the Department shall evaluate the June 30, 2000 per diem in comparison with actual capital expenses at the time and shall consider the feasibility of transitioning from the modified FRV per diem to the FRV per diem, as well as other possible modifications to the methodology.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

D. Beds Excluded from the Transition Policy. Effective July 1, 2000 newly constructed facilities and newly constructed and replacement beds of previously enrolled facilities shall be paid entirely under the FRV methodology without application of the transition policy or the modified FRV per diem. However, facilities and beds with COPN applications submitted as of June 30, 2000, shall be subject to the transition policy and shall have their non-FRV rates calculated under the capital payment methodology in effect as of June 30, 2000. Facilities changing ownership after June 30, 2000, shall be paid the lesser of the full FRV per diem or the transition policy payment of the previous owner. For purposes of this provision, change of ownership shall be defined to include all sales or transfers of stock or assets whether the transactions are between related or unrelated parties.

E. Adjustment for Renovations During the Transition Period. For services during state fiscal year 2001, the capital per-diem applicable to June 30, 2000, shall be the final basis of capital reimbursement. No adjustment to this amount shall be made for renovations completed in State Fiscal Year 2001. For services during State Fiscal Years 2002 through 2005, transition period payments shall be adjusted for renovations according to a methodology that DMAS shall adopt by means of regulations effective July 1, 2001.

F. Adjustment for FRV Savings During the Transition.

1. After the end of each state fiscal year from 2001 through 2005, the Department shall determine the number of Medicaid resident days in the fiscal year that were paid entirely under the FRV method rather than the transition policy. The Department shall multiply the number of these days by the difference between $25 and the applicable FRV per diem. The product is the estimated saving from excluding certain facilities and beds from the transition policy. This amount shall be used to calculate an estimated increase to the modified FRV per diem by

revising the limit on increases above the June 30, 2000 per diem. Savings shall be identified for a state fiscal year after the end of the fiscal year, and shall be used to adjust facility rates effective during the state fiscal year immediately following the one for which the savings were identified. That is, if savings are identified for SFY 2001, all facilities modified FRV per diem rates will be adjusted to reflect those savings effective July 1,2001 through June 30, 2002. The amount of $25 is the estimated capital per diem of a new facility under the methodology in effect on June 30, 2000. This amount shall be reevaluated annually based on the most recent settled cost report data available, and revised if appropriate.

2. The Department shall determine the savings for facilities sold or transferred after July 1, 2000. Savings shall be equal to the difference between the amount of reimbursement the new owner would have received under the reimbursement method in effect on June 30, 2000, and the amount of reimbursement under the FRV method. In the first years after the sale, this amount shall be reduced by the amount of depreciation recapture the seller would have paid based on the reimbursement method in effect on June 30, 2000. This reduction of savings shall continue until the cumulative savings from the FRV method equals the depreciation recapture amount. The amount of estimated net savings shall be used to increase the limits above the June 30, 2000, per diem.

12 VAC 30-90-36. Calculation of FRV Per Diem Rate for Capital. Calculation of FRV Rental Amount. Change of Ownership.

A. Calculation of FRV Per Diem Rate for Capital. The facility FRV per diem rate shall be equal to the sum of the facility FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by the greater of

actual patient days or the product of: 1) the facility's number of licensed beds at the end of the provider's fiscal year immediately prior to the effective date of the rate to be calculated, 2) the required occupancy percentage, and 3) 365 days or 366 days if applicable.

B. Calculation of FRV Rental Amount. The facility FRV rental amount shall be equal to the facility prospective year total value times the rental rate.

1. The facility prospective year total value shall be equal to the facility prospective year replacement value minus FRV depreciation. FRV depreciation equals the prospective year replacement value multiplied by the product of facility average age and the depreciation rate. FRV depreciation cannot exceed 60% of the prospective year replacement value.

2. The facility prospective year replacement value shall be equal to the fixed capital replacement value plus the movable equipment replacement value.

C. Change of Ownership. As provided in connection with Schedule of Assets reporting, the sale of nursing facility assets after June 30, 2000 shall not result in a change to the Schedule of Assets or to the calculation of average age for purposes of reimbursement under the FRV methodology. Therefore any sale or transfer of assets after this date shall not affect the FRV per-diem rate. Changes of ownership for purposes of determining the FRV payment shall occur if there is a sale of stock, assets, or sales between related or unrelated parties.

12 VAC 30-90-37. Schedule of Assets Reporting.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

A. For the calculation of facility average age the Department shall use a "schedule of assets" that lists, by year of acquisition, the allowable acquisition cost of facilities' assets, including land improvements, buildings and fixed equipment, and major movable equipment. Asset allowable costs shall be as determined under rules in effect at the date of acquisition. This schedule shall be submitted annually by the provider on forms to be provided by the Department, and shall be audited by the Department. The principles of reimbursement for plant cost in effect on June 30, 2000, shall be used to determine allowable cost.

B. The schedule of assets used in the calculation of average age shall be submitted with the provider's cost report.

C. Facilities failing to submit the schedule of assets timely shall have their nursing facility per diem rate set to zero when the schedule is 150 days past due.

D. Capital expenditures are to be included on the schedule of assets. These do not include land purchases, but do include land improvements, renovations, additions, upgrading to new standards, and equipment purchases. Capital expenditures shall be capital related expenditures costing $25,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a twelve-month period

E. Items reportable on the schedule of assets may be removed only when fully depreciated (following the straight-line method of depreciation) and disposed of. Depreciation shall be according to the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If an item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

F. Acquisition costs related to any sale or change in the ownership of a nursing facility or the assets of a nursing facility shall not be included in the Schedule of Assets if the transaction occurred after June 30, 2000. Whether such a transaction is the result of a sale of assets, acquisition of capital stock, merger, or any other type of change in ownership, related costs shall not be reported on the Schedule of Assets.

G. Audits of NF allowable capital costs, in addition to verifying the Schedule of Assets, shall continue to audit actual capital allowable expenses as defined under regulations effective June 30, 2000.

12 VAC 30-90-38 to 12VAC30-90-39. [Reserved]

Article 2

Operating Cost Component

12VAC30-90-40. Operating cost.

A. Effective July 1, 2000, operating cost shall be the total allowable inpatient cost less capital cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. Effective July 1, 2000, operating cost shall be made up of direct patient care operating cost and indirect patient care operating cost. Direct patient care operating cost is defined in Appendix I. Indirect patient care operating cost includes all operating costs not defined as direct patient care operating costs or NATCEPS costs in Appendix I. For purposes of calculating the reimbursement rate, the direct patient care operating cost per day shall be the Medicaid portion of the direct patient care operating cost divided by the nursing facility's number of Medicaid patient days in the cost reporting period. The

indirect patient care operating cost per day shall be the Medicaid portion of the indirect patient care operating cost divided by the greater of the actual number of Medicaid patient days in the cost reporting period, or 90 percent of the potential patient days if all licensed beds were occupied throughout the cost reporting period times the Medicaid utilization percentage.

12VAC30-90-41. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. Direct and indirect group ceilings and rates.

   a. In accordance with 12VAC30-90-20 C, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in 12VAC30-90-270.

   b. Effective July 1, 2000, indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, for the

rest of the state for facilities with less than 61 licensed beds, and for the rest of the state for facilities with more than 60 licensed beds. Indirect patient care operating costs shall include all other operating costs, not defined in 12VAC30-90-270 as direct patient care operating costs and NATCEPs costs.

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-95) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

   See 2VAC30-90-300 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall be used to calculate the initial direct patient care operating cost peer group medians. It shall also be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

   a. The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians.

   b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for

the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

c. An SSI rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See 12VAC30-90-300 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

5. Effective for services on and after July 1, 2000, the following change shall be made to the direct and indirect payment methods.

a. The direct patient care-operating ceiling shall be set at 112% of the median of facility specific SII-normalized direct cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998. The median used to set the direct ceiling shall be revised every two years using more recent data. In addition, for ceilings effective during July 1, 2000, through June 30, 2002, the ceiling calculated as described herein shall be increased by two per diem amounts. The first per diem

amount shall equal $21,716,649, increased for inflation from SFY2000 to SFY 2001, divided by Medicaid days in SFY 2000. The second per diem amount shall equal $1,400,000 divided by Medicaid days in SFY2000. When this ceiling calculation is completed for services after June 30, 2002, the per diem amount related to the amount of $21,716,649 shall not be added.

b. Facility specific direct cost per day amounts used to calculate direct reimbursement rates for dates of service on and after July 1, 2000, shall be increased by the two per diem amounts described in subitem a above. However, the per diem related to the amount of $21,716,649 shall be included only in proportion to the number of calendar days in the provider fiscal year the data are taken from that do not fall after July 1, 1999. That is, for a cost report from a provider fiscal year ending December 31, 1999, the specified increase would apply to about half of the year.

c. The indirect patient care operating ceiling which shall be set at 106.9% of the median of facility specific indirect cost per day. The calculation of the median shall be based on cost reports from freestanding nursing homes for provider fiscal years ending in calendar year 1998.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NURSING HOME PAYMENT SYSTEM

1. The initial peer group ceilings established under 12 VAC 30-90-41 shall be the final peer group ceilings for a NF's first or partial cost reporting fiscal year under PIRS. Peer group ceilings for subsequent fiscal years shall be calculated by use of the adjusted medians determined at June 30, 2000, for direct and indirect cost. These adjusted medians shall be considered the 'final' interim ceilings for subsequent fiscal years. The 'final' interim ceilings determined above shall be adjusted by adding 100% of historical inflation from June 30, 2000, to the beginning of the NF's next fiscal year to obtain the new 'interim' ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year.

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.

D. Nonoperating costs. Allowable plant costs shall be reimbursed in accordance with this article. Plant costs shall not include the component of cost related to making or producing a supply or service.

NATCEPs cost shall be reimbursed in accordance with 12VAC30-90-170.

E. The prospective rate for each NF shall be based upon operating cost and plant cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of non-reimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of non-reimbursable

plant costs and NATCEPs costs shall be reflected in the year in which the non-reimbursable costs are included.

F. Effective July 1, 2000, for those NFs whose indirect operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable indirect operating cost rates and the indirect peer group ceilings.

1. The following table presents four incentive examples:

Peer Group Ceilings	**Allowable Cost Per Day**	**% of Difference**	**Sliding Ceiling**	**Scale**	**Difference**
$ 30.00	$ 27.00	$ 3.00	10 %	$ .30	10 %
30.00	22.50	7.50	25 %	1.88	25 %
30.00	20.00	10.00	33 %	2.50	25 %
30.00	30.00	0	0		

2. Efficiency incentives shall be calculated only for the indirect patient care operating ceilings and costs. Effective July 1, 2000, a direct care efficiency incentive shall no longer be paid.

G. Quality of care requirement. A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.